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Volume 59 Number 1 Winter 2013

Marin Medicine

The magazine of the Marin Medical Society

FEATURE ARTICLES

Children's Health

5 INTRODUCTION
How healthy are the children of Marin County?
"How healthy are the children of Marin County? According to the articles in this issue, not as healthy as they could be."
Steve Osborn

7 DEVELOPMENTAL CONDITIONS
The New World of Childhood Disability
"Mental health and developmental conditions now surpass physical conditions as the top five leading causes of disability in children."
Rodney Erwin, MD

11 CHILDHOOD OBESITY
Good News Amid the Bad
"After decades of ever-worsening statistics about the weight of our children, a few pieces of good news have recently emerged."
Tracey Hessel, MD

13 PERTUSSIS IN WEST MARIN
Our Own Epidemic
"Many parents who choose not to vaccinate their children are betting that because certain formerly common diseases are now rare, their child can skip the vaccinations and still not get the diseases."
Michael Witte, MD, and David Bunnett

17 MARIN OUTBREAK
Pertussis: It's Not Just for Babies Anymore
"Since the outbreak, physicians in Marin County have learned much more about pertussis in the 21st century and why an apparently preventable illness surged first here and now around the country."
Paul Katz, MD, MPH

21 PEDIATRIC ASTHMA
Helping Kids Breathe Easier
"Childhood asthma is a common, disabling and potentially life-threatening chronic condition."
Schuman Tam, MD

24 REPORTING CHILD ABUSE
You Simply Need To Pick Up the Phone
"You just might change the course of a child's life if you do make a report."
Cyndy Doherty and Paula Robertson

Table of contents continues on page 2. Cover photo by Alex Porrata (see page 13).

Marin Medicine

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DEPARTMENTS

27 **OUTSIDE THE OFFICE**
Hobbies—You Asked About Hobbies?
"Then comes the exaltation of completion. You can create something no one, in the thousands of years of human activity, has come up with before."
Joan Pont, MD

29 **HOSPITAL/CLINIC UPDATE**
Novato Community Hospital
"Novato Community Hospital has been extremely active in supporting the values of the Patient Protection and Accountable Care Act, strengthening our outpatient programs, and continuing our focus on clinical quality and patient satisfaction."
Ralph Koenker, MD

30 **HOD 2012**
CMA Delegates Set Policy at Annual Meeting
"More than 700 California physicians convened in Sacramento October 13–15 for the 2012 House of Delegates, the annual meeting of the California Medical Association."
Elizabeth Zima and James Noonan

38 **2012 LEGISLATIVE WRAP-UP**
One Must Imagine Sisyphus Happy
"In years past, the California Medical Association has defended physicians in battles waged by hospitals, health plans and mid-level practitioners, but this year we initiated a few fights of our own."
Jodi Hicks

40 **CURRENT BOOKS**
To Think, Perchance to Scheme
"The complexity of the human brain—along with the self-awareness that sets us apart from other animals and from computers—has given us a great evolutionary advantage; but that complexity has also resulted in a susceptibility to mental illness."
Irina deFischer, MD

39 **NEW MEMBERS**

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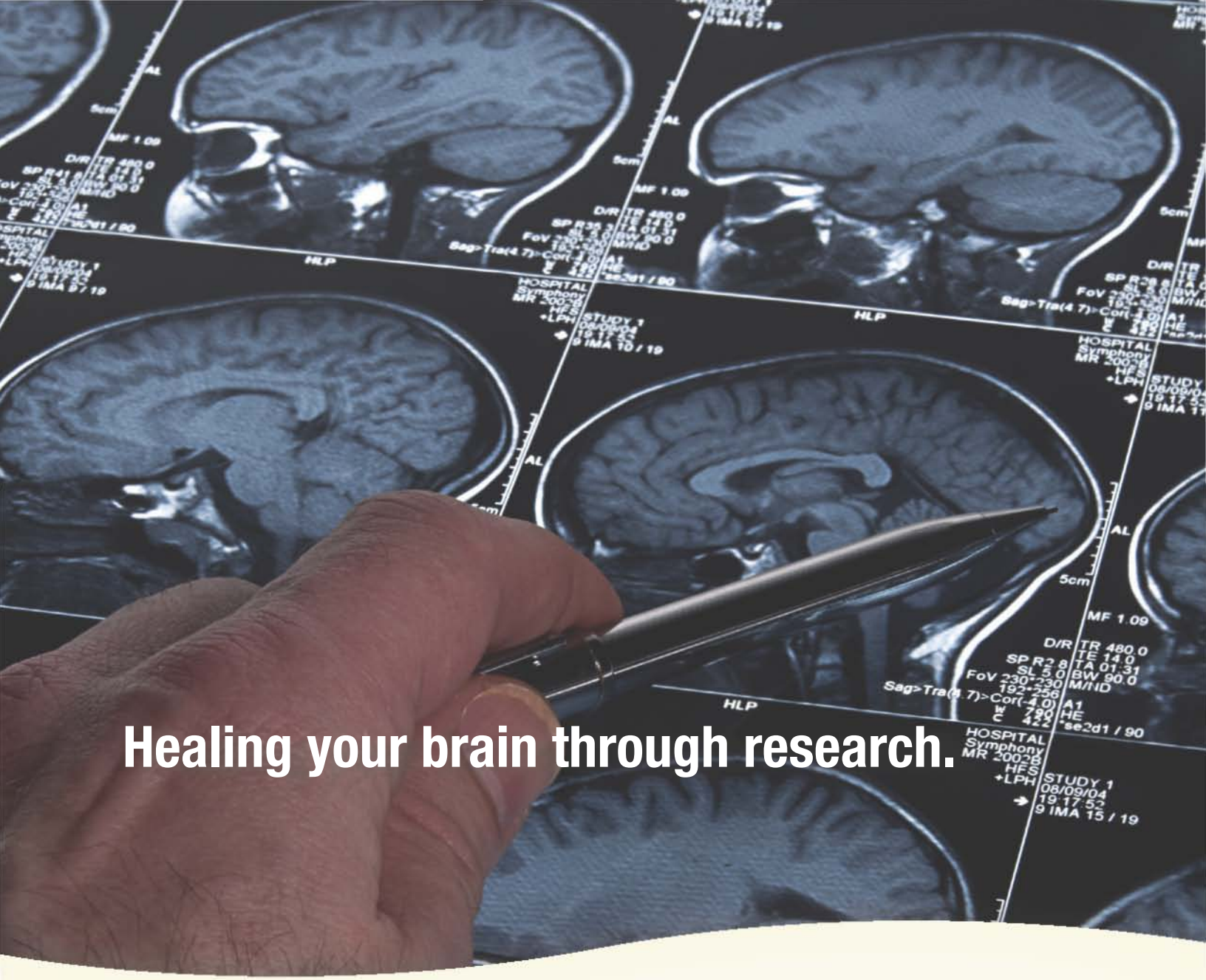

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How healthy are the children of Marin County?

Steve Osborn

How healthy are the children of Marin County? According to the articles in this issue of *Marin Medicine,* not as healthy as they could be. Like their adult counterparts, they suffer from obesity, asthma and infectious diseases. They are also prone to developmental conditions, mental illness, and perhaps worst of all, abuse at the hands of their elders.

The news is not all grim, however. Betwixt and between the various appalling statistics, a few rays of sun shine through. More light may appear if medical science and art continue to make the progress described in some of the articles. A key element of that progress will be recognizing the problems that currently exist and identifying possible solutions.

One of the biggest problems may come as something of a surprise. As noted by Dr. Rodney Erwin, a child & adolescent psychiatrist at Kaiser Petaluma: "Mental health and developmental conditions now surpass physical conditions as the top five leading causes of disability in children in the United States." Twenty years ago, respiratory diseases topped the list, but they've since been displaced by speech problems, learning disabilities and ADHD, among others. Coping with these "new morbidities" is a daunting task, writes Dr. Erwin, and it will require a coordinated approach from all concerned.

Another problem in need of a coordinated approach is childhood overweight and obesity, which now affects a quarter of the children in Marin. Dr. Tracey Hessel, the lead pediatrician at Marin Community Clinics, reports some individual successes in treating obesity, but she believes that truly impacting the epidemic "will require more than any of us can offer through individual counseling in the office setting. It will require changes in our schools, our neighborhoods, and our public policies."

Public health departments are trying novel strategies to address rising childhood obesity. Even as they do so, they may need to revise their approach for one disease that used to be falling: pertussis. As detailed in a pair of articles, Marin County was at the epicenter of California's 2010 pertussis epidemic, and the repercussions are still being felt.

The first article, by Dr. Michael Witte and David Bunnett, gives an inside view of the epidemic in West Marin, where Dr. Witte directs the Coastal Health Alliance. That area has a particularly high rate of Personal Belief Exemptions from parents who choose not to vaccinate their children. For parents unfamiliar with the deadly history of pertussis, writes Dr. Witte, "Fears of disease have been replaced by a fear of hurting their most precious responsibility, their baby, with a perceived unnecessary danger of immunizations." Physicians, he believes, will need to use all their powers of persuasion to change parents' minds.

The second pertussis article, by Kaiser San Rafael pediatrician Dr. Paul Katz, describes how he and his colleagues were able to trace much of the epidemic to the limited efficacy of the new acellular vaccine. They discovered that 8–12 year-olds were susceptible, even if up-to-date on their vaccines. "The unimmunized were the spark," he observes, "and the fully immunized but susceptible preadolescents were the kindling and the fuel."

Pertussis may rise and fall, but the incidence of asthma continues to increase at a steady pace. The disease now affects almost one-tenth of children aged 0–19, notes Greenbrae allergist Dr. Schuman Tam. He describes several important clinical trials over the past two decades that have tried to establish the most effective treatments for this complex and persistent condition.

Unfortunately, not all threats to children's health can be solved by medications. Child abuse is an ancient scourge that lurks everywhere, even in bucolic Marin. As detailed by child welfare professionals Cyndy Doherty and Paula Robertson, physicians are legally mandated to report suspected abuse. Just one phone call is all it takes.

The picture of childhood that emerges from these feature articles is naturally skewed by the focus on disease. This is, after all, a medical magazine. But for most children, coping with disease is just a small part of growing up. A much larger part is devoted to learning skills that persist into adulthood.

In our "Outside the Office" department, San Rafael internist Dr. Joan Pont describes two such skills: weaving and horseback riding. "I am coming to realize that I can learn nothing new," she reflects. "I am just recycling skills learned as a child."

For this issue, then, you are invited to employ the childhood skill of reading. The words await you. ◇

Mr. Osborn edits Marin Medicine.

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The New World of Childhood Disability

Rodney Erwin, MD

Children with developmental conditions experience daily social and emotional defeats from their inability to regulate their minds and bodies in an acceptable way. Delays in speech isolate and frustrate children. Learning disabilities can serve to make the natural human instinct of curiosity and learning more of a burden and challenge than a life-giving joy. Depression deadens the vitality of youthful energy and excitement, and anxiety can make going to play soccer with friends a terrifying experience. Kids with autism spectrum disorders see the world through very different lenses than the rest of us, and they fight constantly to communicate with a world that does not and may never speak their language.

Mental health and developmental conditions now surpass physical conditions as the top five leading causes of disability in children in the United States.[1] According to data from the 2009 National Health Interview Survey, 7.7% of children under the age of 18 had some kind of limitation that prevented them from engaging in their usual activities.[2] The top five disabilities are speech problems; learning disability; attention deficit hyperactivity disorder (ADHD); other emotional, mental, and behavioral problems; and other developmental problems. Asthma or breathing problems came in sixth.

Dr. Erwin is a child & adolescent psychiatrist at Kaiser Permanente in Petaluma.

"This news is definitely not surprising," observes Dr. Nelson Branco, a pediatrician at Tamalpais Pediatrics in Greenbrae and Novato. He says there has been a growing discussion in pediatrics about the "new morbidities" over the past decade, as behavioral and developmental issues have loomed ever larger. Parents have become much more educated and aware of developmental diagnoses, and the training of pediatricians has shifted to include more developmental surveillance and increased use of validated screening tools for mental and developmental conditions. As a result, many more children are being diagnosed with developmental conditions that may formerly have been overlooked, misunderstood or unaddressed.

Many factors are undoubtedly contributing to the increasing prevalence of mental health and developmental disabilities in children. Studies have tried to separate out the role of improved detection and screening for these disabilities, as well as changes in diagnostic criteria and thresholds for diagnoses. One study, for example, revealed that a family's social proximity to another family with an autistic child significantly increased the likelihood of the first family's child being diagnosed with an autism spectrum disorder (ASD).[3] The authors found that a child who lives within 250 meters of another child with autism is 42% more likely to be diagnosed with autism than a child living farther away. Living 250–500 meters away reduced the likelihood to 22%. The study also showed that ASD diagnoses obeyed the demarcations of school districts, supporting the hypothesis that school and parental knowledge of ASD led to higher rates of diagnosis.

Detection and screening factors alone, however, cannot explain the increase in mental health and developmental disabilities in children. Much has been made, and rightfully so, of the astounding increase in ASDs during the past two decades. The rate of autism diagnosis in California of children younger than five years, for example, increased from 6.2 per 10,000 births in 1990 to 42.5 in 2001.[4] The CDC now estimates that 1 in 88 children in the United States has an ASD, and the statistics are even more sobering for the prevalence of ADHD: almost 1 in 10.[5,6] Data from the National Health Interview Survey mentioned above show a fourfold increase in the prevalence of childhood disability overall in the past 50 years.[2]

Evidence is also mounting with regard to genetic and environmental influences in the increasing rates of developmental disabilities. Genetic and twins studies in ASDs are increasingly supporting the idea that there is an as-yet-unidentified environmental component to the development of these disorders. One recent study showed a statistically significant association between the risk for an ASD diagnosis and the distance from power plant emissions of mercury.[7] Several other environmental toxins have been linked to developmental conditions in children. Prenatal exposure to tobacco, for instance, more than doubles the likelihood of an ADHD diagnosis.[8] If children were also exposed to lead and tobacco, the likelihood of having ADHD goes to eight times that of children who had neither exposure. Exposure to organophosphate pesticides, mercury and polychlorinated biphenyls has also been associated with increased risk for ADHD.[9]

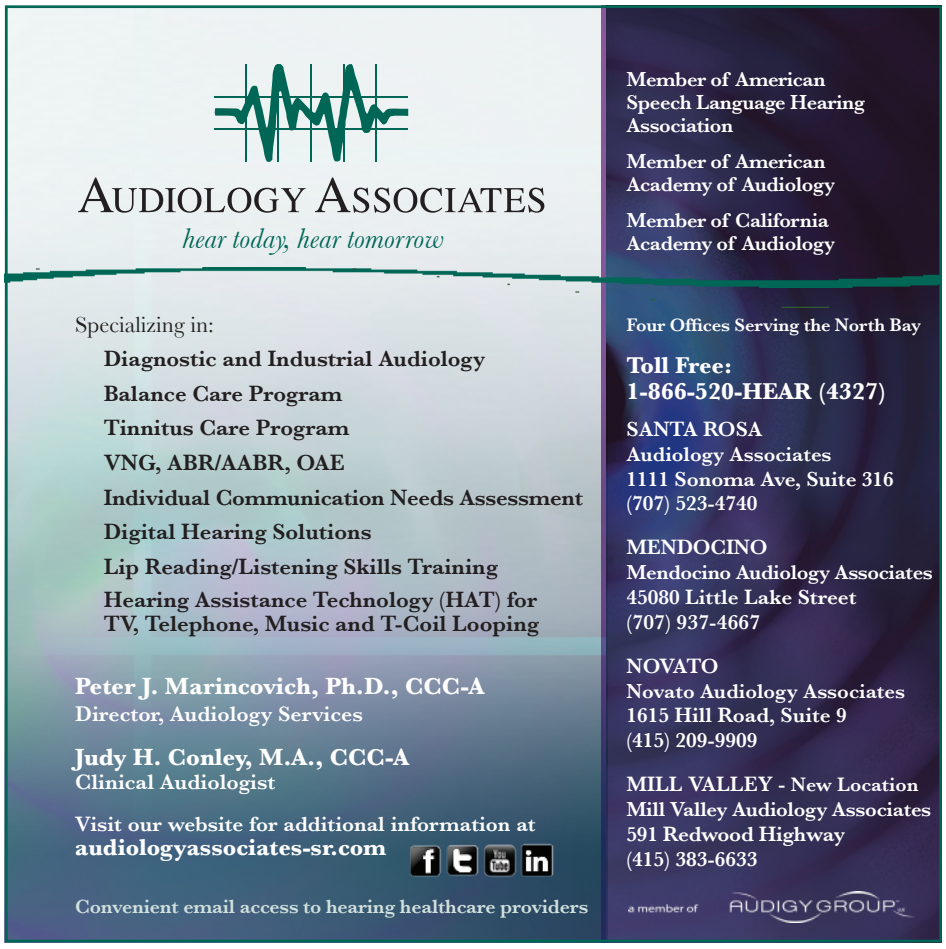
Identifying these associations raises some hope about eventually developing more effective prevention of developmental conditions in children. Preventive measures are especially important given the impact that mental health and developmental disabilities have on the future of children and their families. Research shows that childhood mental health difficulties have a much more profound negative effect on several critical adult outcomes than physical health problems. Adults who had childhood mental illness end up with fewer educational opportunities, fewer weeks worked in a year, and lower individual and family income.[10] Having a mental health diagnosis as a child is associated with a 37% decline in family income as an adult, which is three times more than the expected decline in income from a childhood physical health problem.

The future impacts of childhood mental health and developmental disabilities are staggering when one considers the increasing prevalence of these conditions. Perhaps even more important, there is a vital need for adequate assessment and effective treatments and support. The very nature of these conditions demands coordinated and comprehensive care in an effort to involve the affected child, families, schools and communities in a truly biopsychosocial medical approach.

Relative to other communities throughout the country, Marin and Sonoma counties have an abundance of resources, including child and adolescent psychiatrists, neuropsychologists, occupational and speech therapists, educational specialists, and student/family advocates. Nonetheless, many local children are unable to access these resources because they are too expensive, especially on a chronic basis.

There is a significant risk that the availability of services and treatment will only get worse in the coming years. The California Legislature and Gov. Jerry Brown have agreed to eliminate the Healthy Families program by next September, at which time the 863,000 California children enrolled in the program will be transitioned to Medi-Cal. This transition will further limit access to mental health care for children. Children in Healthy Families, for example, are currently able to receive mental health care at Kaiser Permanente. Because Kaiser does not have a contract to provide these services through Medi-Cal, those families will have to find providers in the community who accept Medi-Cal patients. Many of these providers work in county mental health systems, which themselves are struggling to survive under further budget cuts. School districts are also facing overwhelming financial pressures and are cutting psychological and support services.

The silver lining to this grim situation might be greater attention to the ongoing mental health needs of children. Over the past decade, physicians in pediatrics and certainly in child and adolescent psychiatry have observed the increased frequency and intensity of their young patients' mental health



and developmental challenges, and they have worked diligently to develop better identification and treatment. The needs of these children, however, now require a much more systematic and broad-scale approach that relies on integration and coordination of services with a multitude of various medical providers and schools. Developing basic access to ongoing treatment is critical, even in Marin and Sonoma counties, with their wealth of resources.

Continuing to educate and inform parents, teachers, health care providers and the general public about these issues is vital to transforming the still pervasive negative perceptions of mental health and developmental issues. Similar to children who use inhalers before PE class, or wear glasses, or use a ramp to enter school, it is imperative for children with developmental conditions to understand their situation and find ways to overcome their disability. This effort will require the destigmatization of psychiatric and developmental disorders. Children with ADHD who continue to get into trouble in school are not just defiant or obnoxious. The little girl with autism who is melting down in the grocery store is not just badly parented. The child who refuses to read or write because it is such an incredible challenge is not stupid or lazy. All these children have medical and developmental conditions that deserve support, understanding and effective treatment. ◇

Email: rodney.j.erwin@kp.org

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Good News Amid the Bad

Tracey Hessel, MD

After decades of ever-worsening statistics about the weight of our children, a few pieces of good news have recently emerged, along with evidence that people are starting to take the childhood obesity epidemic seriously. Nonetheless, we still have a long way to go to significantly impact a phenomenon that is affecting a quarter of Marin's children.

According to a recent statewide study, we may be starting to make small amounts of headway toward reducing the scope of the problem.[1] Researchers found that the prevalence of overweight or obesity in 5th, 7th and 9th graders in California decreased by 1.1% from 2005 to 2010. However, 38% of the children statewide are still overweight or obese—triple the rate of 30 years ago. Marin County, with 24.9% of children overweight or obese, had the lowest level in the state, although the local rate has increased over the past five years.

Other recent studies have highlighted the dramatic disparities in health and well-being between different geographic regions within Marin.[2,3] Not surprisingly, these disparities are also true for overweight and obesity, with children living in Novato and San Rafael having rates 10% higher than those of the county overall.

The children we treat at Marin Community Clinics don't have private insurance, and most face multiple economic and social barriers to making healthy lifestyle changes. A large part of my clinic day is spent counseling children and their families about adopting changes in their daily lives that will improve their fitness and reduce or at least stabilize their weight. The basic messages are simple: limit sugared beverages, increase fruits and vegetables, limit fast food, be active every day, and decrease screen time. But, as is true of most of the behavioral changes recommended to our patients young and old alike, these simple concepts prove difficult to adopt and sustain.

Over the past decade, I have observed a positive change in awareness of childhood obesity among the families I treat. Most are concerned when their child is identified as being overweight and often have already taken steps to reduce sodas and junk food in their diets. However, they may need help seeing past the marketing to recognize similar sources of excess calories, for example in sport drinks, juices, and other more healthy-appearing options.

One of the more surprising factors limiting families' success in adopting nutritious diets is the "food desert": a geographic area without easy access to affordable, healthy foods. Within Marin County, several areas of Novato and San Rafael have been classified as food deserts by the U.S. Department of Agriculture. The typical local options for families who live in these areas are limited to convenience stores, liquor stores and fast-food restaurants. Making healthy choices for residents of these areas is especially challenging.

Another factor that impacts many children is "food insecurity": lacking the financial resources to regularly purchase food. In the most severe situations, food insecurity can result in hunger. In other cases, there is a strong relationship between food insecurity and overweight, along with consequences such as diabetes. Studies of at-risk populations have shown that people with food insecurity often limit the variety of the food they purchase.[4] They end up concentrating on lower-cost, energy-dense but nutritionally lacking foods, such as refined carbohydrates with added sugars, fats and salts.

From the parents I work with who are motivated to improve the diets of their children despite these challenges, I have also heard frustration that their ability to impact their child's overall health is limited. A growing number of children in Marin (upwards of 50% in San Rafael Elementary and Sausalito/Marin City school districts) qualify for the free meal program. Many of these children receive both breakfast and lunch at their school. If they receive additional instruction or childcare in an after-school program, they will also likely receive an additional snack at school. Thus, the nutritional content of those school meals contributes greatly to their overall health.

Even though school meals meet minimum federal nutritional guidelines, they leave much to be desired in terms of providing fresh, healthy and minimally processed foods to our children. Local schools have recently made some positive efforts to improve their nutritional offerings and opportunities for physical activity. School districts have adopted wellness policies that set

Dr. Hessel is the lead pediatrician at Marin Community Clinics.

guidelines around physical activity; establish nutritional expectations for foods sold at school or used in classroom parties; and define minimum standards for the health-education curriculum.

In addition, several programs provide healthy foods to supplement school meals. San Rafael elementary schools, for example, now have salad bars with fresh produce. Some schools have their own vegetable gardens or participate in Farm to School programs that promote the use of local produce and teach students about the origins of their food. Nonetheless, the biggest obstacle to improving the actual meal offerings is the limited funding for school lunches. The budget per student per meal, including milk, is approximately one dollar.

Of all of the unhealthy behaviors I address with children, the one I have the most trouble impacting is lack of exercise. The goal of having children be active every day seems like it should be easy to attain. But exercise, like food, is subject to socioeconomic constraints. Few of the elementary school students in Marin participate in a physical education class every day; some participate only once a week. Moreover, parents with limited means often report being unable to afford the equipment and uniforms needed to enroll their children in sports. Even outside of school, parents sometimes feel that it is unsafe to let their children play in their crime-ridden neighborhoods.

As I work with families, I experience what is being reported nationally by those trying to address the problem of overweight and obesity. There are successes, modest for my practice overall, but thrilling for children and families who are able to make significant changes, experience improved weight and fitness, and integrate healthy habits into their lives. Despite these small successes, I am convinced that truly impacting and reversing the epidemic of childhood obesity will require more than any of us can offer through individual counseling in the office setting. It will require changes in our schools, our neighborhoods, and our public policies.

While making healthy lifestyle choices is ultimately up to the individual (or the individual's parents, depending on their age), it is important to acknowledge the challenges created by misleading marketing, limited access to affordable and nutritious foods, and lack of opportunities to play safely. We can't force changes upon individuals, but we can work to create an environment conducive to success. As stated by the Robert Wood Johnson Foundation, "The environments we live in and the public policies our leaders enact directly impact the foods our children eat and how much activity they get."[5]

This year, the Marin County Department of Health and Human Services assembled a diverse group of agencies throughout the community who work with children and families to promote the Healthy Eating and Active Living (HEAL) program. Through HEAL, a strategic plan is being developed to impact health in Marin through improved nutrition and physical activity. This is an exciting development, but HEAL will need the advocacy and support of our colleagues and neighbors to prioritize the creation of healthier communities for all our children.

As with an individual or a family, how we choose to spend our money reflects our values and priorities. With California's per capita spending on education 47th in the nation, our schools don't have a lot to work with. Physical education is an unfunded mandate; in most schools it is provided by PTAs, school foundations or outside grants. We've budgeted just one dollar per meal to provide food to children who are most at risk for food insecurity.

With a quarter of Marin's children overweight or obese, this is the first generation that may have a shorter life expectancy than their parents. We can change that, but it will take a commitment to creating healthier communities throughout Marin. In a county known for its wealth and natural beauty, it doesn't seem like such a stretch to imagine a Marin where children regularly receive nutritious meals and participate in daily vigorous activity—where all communities have access to parks, accessible sport programs, bike paths, and markets with affordable, nutritious foods. ◇

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Our Own Epidemic

Michael Witte, MD, and David Bunnett

Yolanda "Yoli" Powell, daughter of Ron Powell and Alex Porrata of Inverness, contracted pertussis in 2007 at less than two months of age. The disease was transmitted to Baby Yoli by an adult family member who thought she only had a persistent cold. Yoli spent eight days in an isolation ward at Kaiser Santa Rosa. Full recuperation took over three months, and she received special therapy to help make up for developmental milestones that the prolonged illness may have interfered with. The therapy must have worked, because she is developing just fine now.

(Photo courtesy of Alex Porrata.)

Pertussis, commonly called whooping cough, is a highly contagious disease that is potentially fatal for infants and small children. Seventy years ago, it was a leading cause of infant mortality in the United States, but within just a few years after that, effective vaccinations had nearly eliminated it as a major public health concern. Now, whooping cough is making an unwelcome comeback. In 2010, Marin County—listed by the Centers for Disease Control as the healthiest county in the United States—had the highest incidence of pertussis in California, a rate high enough to qualify as an epidemic.

This remarkable local story begins with some historical context. Up to the early 1940s, reported cases of pertussis were as high as 250,000 per year in the United States, with as many as 9,000 yearly deaths, mostly of infants. Because of population growth since then, today those rates would be equivalent to 590,000 annual cases and 21,000 yearly deaths. Thanks to vaccinations, however, the average national incidence of pertussis had been reduced to around 2,900 cases by the 1980s.

Unfortunately, the prevalence of pertussis has been gradually increasing in the last two decades, for reasons that are not entirely clear. One contributing cause may be that the pertussis vaccine was reformulated as an acellular vaccine to reduce the reaction to the injection itself: the original whole-cell vaccine had caused redness, swelling and pain for up to half the children receiving it. The newer, gentler vaccine is effective, but it appears to be less long-lasting than the previous formula. Another cause may be the choice of some parents not to vaccinate their children for a variety of reasons, including religious beliefs, alternative medical ideas, or concern about the safety of the vaccine itself.

Whatever the cause, the more recent facts and figures about pertussis are disturbing. In 2010, there were 27,550 new pertussis cases and 27 deaths reported nationwide—a 10-fold increase compared to the 1980s average. The 2010 epidemic was especially severe in California, which had over one-third of all U.S. cases and 10 of the deaths. Within California in 2010, the greatest incidence of pertussis was in Marin

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Dr. Witte, a pediatrician and family physician, is medical director of the Coastal Health Alliance in western Marin County. Mr. Bunnett serves on the board of directors of the Alliance and writes for the West Marin Citizen, *where portions of this article originally appeared.*

County. At 138.4 cases per 100,000 population, Marin's incidence rate was nearly six times the state average. There were 351 total cases in Marin that year, but thankfully no deaths.

Marin was hit hard in 2010—in terms of incidence rate, harder than any county in the state. As the CDC cautions, this fact cannot be definitively attributed to a single cause. Statewide, there was some randomness in where outbreaks occurred. Urban areas were more likely to suffer at least some exposure to an infectious outbreak, and some of the more sparsely populated counties (Alpine, Modoc, Sierra, Trinity) reported no pertussis cases at all in 2010. On the other hand, Mono County was also very hard hit, while the biggest cities reported an incidence of pertussis far below that of Marin— about one-eighth Marin's rate for San Francisco, and about one-tenth for Los Angeles.

While there is randomness in the geographic distribution of outbreaks, there is no lack of clarity about what caused the overall risk of pertussis to decline so much since 1945: it was the vaccinations. Indeed, California state law requires children entering kindergarten to show proof of vaccination. However, parents who do not want their child vaccinated can avoid this requirement by signing a Personal Belief Exemption (PBE). According to Marin County Immunization Coordinator Sharayn Forkel, in 2010 the statewide average rate of children with PBEs was 2.3%, whereas the Marin County rate was 7.1%—more than three times the state average.

Again, the CDC is cautious about attributing the increase in pertussis to specific causes. But at the very least, the comparison of Marin's 2010 incidence of pertussis (highest in the state) with Marin's rate of unvaccinated schoolchildren (more than three times the state average) is worthy of attention. Even more worthy of attention are the following statistics from West Marin, where Dr. Witte practices:

- Percentage of children entering kindergarten in Bolinas-Stinson School in 2011 who had a PBE for one or more vaccines: **27%**
- Percentage of children entering kindergarten in Lagunitas School in 2011 who had a PBE for one or more vaccines: **50%**

These PBE rates for pertussis and other vaccines should set off all kinds of alarms among those concerned with public health.

Many parents who choose not to vaccinate their children are betting that because certain formerly common diseases are now rare, their child can skip the vaccinations and still not get the diseases. In individual cases, they might win that bet.

The concept of "herd immunity" is central to this belief. Under this logic, assume that a certain (high) percentage of a community has protection against getting an infectious disease, through either having had the disease and survived it, or having been vaccinated successfully against it. In that case, the prevalence of the disease drops to near zero, since the germ can't find enough susceptible hosts to carry it around and keep it alive.

Often without being consciously aware of it, parents who rely on herd immunity to protect their children are counting on most other parents vaccinating their kids, so that the disease won't survive and spread in their part of the "herd." Ms. Forkel, the immunization coordinator, is not fond of this strategy. She points out that only about 10–15% of the population can forgo immunization before herd immunity is lost. That margin should be reserved for newborns, those who truly can't tolerate vaccination due to allergies or physical frailty, and those without access to vaccinations. Generally healthy individuals who choose not to be vaccinated are putting others at risk, not just themselves. When the number protected by vaccinations drops below about 85%, the germ finds enough available hosts to keep it alive and traveling around. This is likely what happened in Marin in 2010.

Larry Enos, superintendent of both the Bolinas-Stinson and Lagunitas school districts, says that Bolinas-Stinson parents have substantially reduced their use of PBEs this year. In Lagunitas, the rate of 7th graders with PBEs declined from 41% in 2011 to 28% in 2012. On the other hand, of the 25 new kindergarten students starting at San Geronimo School in September 2012, 56% had exemptions to some or all of the required immunizations due to PBEs.

Enos was diplomatic in his statements about the vaccination controversy. He made it clear that he absolutely respects both the sincerity and the legal rights of parents who choose not to vaccinate. But he also added: "I would hope that people will consider carefully before refusing immunization for their children."

In an influential article on improving vaccination rates published earlier this year, Dr. Douglas Diekema found inspiration in the ancient Greek phi-

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losophers: "In *The Art of Rhetoric,* Aristotle argued that persuasion requires not only a reasonable argument and supporting data, but also a messenger who is trustworthy and attentive to the audience and a message that engages the audience emotionally. Data and facts, no matter how strongly supportive of vaccination, will not be sufficient to compete with the opposition's emotional appeals. The use of a compelling story about a single victim of vaccine-preventable illness is far more likely than data to move an audience to action."[1]

In Marin County, we are blessed with some of the best health and healthcare in the United States. The diseases that used to kill or infect many infants and children have been removed from the community and from parents' fears. Those fears of disease have been replaced by a fear of hurting their most precious responsibility, their baby, with a perceived unnecessary danger of immunizations.

Our job as physicians is twofold. On the one hand, we need to present the science behind the immunization risk, the true risk/benefit ratio of vaccines and the concept of herd immunity. On the other hand, we should also convey stories of the dangers our grandparents faced with their children. Most importantly, through motivational interviewing and other techniques, we should respect our patients' fears and the information they come to us with. If we engage our patients emotionally, we are more likely to persuade them to vaccinate their children. ◇

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PERTUSSIS: THE CLINICAL PICTURE

Symptoms

Initial symptoms of pertussis (whooping cough) may resemble a common cold. A persistent cough typically develops after a week or two. Long, convulsive bouts of numerous, rapid coughs are interspersed by a characteristic high-pitched whoop as the patient attempts to draw a breath. During coughing episodes, the patient may turn blue. Vomiting and exhaustion often follow coughing episodes.

The intensive coughing stage typically lasts from 1 to 6 weeks but can extend as long as 10 weeks. During convalescence, coughing episodes may recur for a period of months.

Symptoms may be milder in older children or adults. However, they may still transmit the disease to others, especially unimmunized or partially immunized infants and young children.

Complications

Children less than six months of age are the most likely to develop complications. The most common is bacterial pneumonia, which is also the primary cause of deaths from pertussis. Possible complications may include seizures, ear infections, and dehydration, among others. For adults, rib fracture from coughing is also possible.

Preventive measures

Pertussis is highly communicable. It is transmitted primarily through contact with respiratory droplets—that is, by coughing or sneezing. It can also be spread by contact with freshly contaminated objects.

The DTaP vaccination is the best defense against pertussis (or TDaP, slightly differently formulated for older children and adults). Babies are normally vaccinated at two months, and are defenseless before that. Pregnant women and families with young babies are advised to make sure that adults and older children who will be in contact with the infant are protected by up-to-date vaccinations. Ideally, all family members of babies under 2 months should be immunized against pertussis to "passively" protect the baby.

Good coughing etiquette (cover the mouth and turn away when coughing or sneezing) and hand washing are simple ways to reduce transmission of many communicable diseases, including pertussis.

Diagnosis

Pertussis has three clinical phases: catarrhal, paroxysmal and convalescent. The catarrhal phase acts like the common cold, but is prolonged, and then followed by the paroxysmal coughing phase which can last several weeks. Patients who have been immunized may still get symptoms, but they are typically milder. Laboratory testing by culture or PCR testing of the deep nasopharynx is most reliable early in the catarrhal phase. The problem with this approach is that suspicion of pertussis often doesn't arise until the paroxysmal phase, when the tests are less reliable.

Treatment

Antibiotic treatment of pertussis has only shown to be clearly effective within 21 days of the onset of symptoms. This would mostly be true then in the early catarrhal stage. The emphasis in treatment being early should mean that family members and others likely exposed should be treated at the first onset of symptoms. Macrolide antibiotics, erythromycin, clarithromycin and azithromycin are all effective against pertussis. Trimethoprim-sulfa is also effective as an alternative.

Where to get vaccinations

For access to vaccinations in West Marin, regardless of ability to pay, patients should contact the Coastal Health Alliance at these numbers:

- Point Reyes Station: 415-663-8666
- Bolinas: 415-868-0124
- Stinson Beach: 415-868-9656

Elsewhere in the county, patients should contact their regular primary care provider for a TDaP booster shot. For uninsured patients who have difficulty affording the TDaP immunization, a limited number of free vaccines are available at several clinic sites throughout the county.

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Pertussis: It's Not Just for Babies Anymore

Paul Katz, MD, MPH

Only three years ago pertussis was a dusty memory. For physicians, the idea of pertussis (whooping cough) called up long-ago medical school lectures, visions of old and rarely used cough plates, and an arcane consideration in cases of unexplained chronic cough. Whooping cough seemed to be one of those maladies vanquished by immunizations—another victory over infant death. Then, in 2010, pertussis came back in a big way, and Marin County was ground zero: the epicenter of a whooping cough outbreak that was by far the largest and most sweeping in California in 50 years. In its wake, 10 infants throughout the state died preventable deaths, and many lives were thrown into turmoil.

Since the outbreak, physicians in Marin County have learned much more about pertussis in the 21st century and why an apparently preventable illness surged first here and now around the country. The biology of pertussis has not changed all that much over the years, but the population that is susceptible to the illness certainly has. And now a new question looms: Will the burden of future outbreaks be just with infants and children?

To tell the story of Marin's pertussis outbreak and what it means, let me begin with a brief personal narrative. In January and February 2010, my

Dr. Katz is a pediatrician at Kaiser San Rafael.

pediatric colleagues and I at Kaiser Permanente in San Rafael noted several cases of an odd, persistent, even paroxysmal cough in several of our patients. First there was one case of pertussis verified by the nasopharyngeal PCR (polymerase chain reaction) test, then two, then more. Each week, we sent one or two Confidential Morbidity Reports for pertussis to the Public Health Department. More and more family members were being treated for prophylaxis, and some were tested for their own coughs.

Around that time, Dr. David Witt of Kaiser's Infectious Diseases Service and I noted a cluster of cases in a West Marin community. The cluster seemed to be centered around the adolescents and preadolescents in school there. The community also happened to have a high rate of vaccine refusers and of Personal Belief Exemptions for vaccines in the local schools. When I encouraged parents to raise awareness of pertussis in the community and the school, I heard several times from them that their children's peers had been to their doctors and had not been tested for pertussis for emerging paroxysmal coughs. What those parents heard was that if their child was immunized they were not at risk for whooping cough or that pertussis was not really a problem for older children or teens. Of course, what families heard may not have been exactly what the doctors said, but clearly those beliefs were out there.

Two issues bothered me deeply. First, pertussis vaccine was even then known to be imperfect. At the time, the effectiveness of the vaccine was thought to be 90% in optimal conditions. Second, the North American acellular pertussis vaccine that had been around since 1991 and had fully replaced the original whole-cell pertussis vaccine by 2001 had never been studied in an outbreak situation. Would that 90% effectiveness measured in the usual background of rare endemic exposure hold up to a classroom where two or three children are coughing actively with pertussis for weeks before being treated or considered for treatment? Would density of exposure affect the efficacy of the vaccine?

By the start of March, we were sending in two Confidential Morbidity Reports per day for pertussis rather than one or two per week. Clearly this was not just a few cases, but was in fact an outbreak. Fortunately, we had good tools in our practice. We had access to the PCR test on nasopharyngeal speci-

mens with a 24-hour turnaround time. We had a large known population at Kaiser (40% of the insured population of Marin County) that would get its medical care only though our system. We had systems and a workflow in place to rapidly treat suspected cases and their contacts. Finally, we had dedicated pediatricians and child health providers who were used to working together as a team.

In March, we established a Practice Agreement at Kaiser San Rafael to test and treat for possible pertussis uniformly during the outbreak. All pediatric patients with a persistent cough for more than a week without other explanation (e.g., asthma, pneumonia, sinusitis) were to be assessed with a PCR test. All close or family contacts of known cases with any cough symptoms of any duration were also to be tested. The Practice Agreement not only allowed us to test and manage pertussis clinically in a public health crisis, but also to look at pertussis attack rates in an outbreak without selection bias based on immunization status. Pediatricians only decided whether or not to test for pertussis based on the clinical situation—not on whether the patient was up to date on pertussis vaccine.

Despite identifying more than 200 cases of pertussis by the end of 2010, when the outbreak came to an end, we had no deaths and almost no hospitalization of our patients for pertussis. However, when Dr. Witt, our research assistant (his son Max) and I looked at our attack rates, something jumped out: pertussis peaked in older school children and preadolescents, not in teens and not in babies. Pertussis vaccine effectiveness in the outbreak was hugely different by the age of the child. The effectiveness in 13–18 year olds was 79%, meaning that a fully immunized 14-year-old, for example, had 79% less chance of getting pertussis than an underimmunized or unimmunized 14-year-old. In contrast, the vaccine effectiveness for 8–12 year olds was only 24%.

When we compared our results to the nationally recommended vaccine schedule and looked at the length of time from last vaccine to cases, we found that the immunity of the acellular pertussis vaccine seemed to wane in our outbreak at about three years after vaccination. Most children finished their kindergarten vaccines at 4 or 5 years old and were not to be boosted until at least 11 years old (and often not until 12 or 13). As a result, children from 8–12 years old would be fully vaccinated by the recommended schedule but still quite susceptible to pertussis in an outbreak situation. We presented our findings at the American Society of Microbiology meetings in the fall of 2011 and published them in March 2012.[1]

So why did the pertussis outbreak seem to start in Marin County? And why in 2010? To answer these questions, we need to go back in history. Pertussis was a frequent cause of infant death in the United States during the first half of the 20th century. Between 1926 and 1930, for example, more than 36,000 American children died of whooping cough. In the 1930s, Pearl Kendrick and Grace Eldering developed the whole-cell pertussis vaccine at the Michigan Department of Health by inactivating pertussis bacilli with thimerosal for more than a week in a cold but not frozen temperature. The vaccine was recommended for routine use by the American Academy of Pediatrics in 1943, and by 1948, pertussis mortality had dropped to near zero.

Concerns about rare but severe neurologic adverse effects led to decreasing acceptance of the pertussis vaccine during the late 1970s and 1980s. The scientific community and pharmaceutical industry responded by developing the acellular pertussis vaccine. The new vaccine seemed effective in studies lasting up to 22 months after administration. Measurable antibody levels to the targeted antigen in pertussis were similar to the whole-cell vaccine. In 1991, the acellular vaccine came on the market as a childhood booster. By 1997, the acellular had supplanted the whole-cell vaccine in most practices and was inserted into the same schedule as the whole-cell vaccine. By 2001, the whole-cell vaccine was no longer available.

For the next nine years, pertussis continued to occur in low endemic rates of illness, and no prominent outbreak was noted. The number of families refusing vaccine on personal belief exemptions increased, however—especially in Marin County, which has the highest rate of PBEs in the state. People with similar beliefs and culture tend to cluster together, and the same is true for vaccine refusers, as witness specific communities in western Marin.

By 2010, Marin County had the perfect set-up for a pertussis outbreak. By that year, everyone under 10 and almost everyone under 14 was naive to whole-cell pertussis vaccine. Since the vaccine schedule leaves a six- to eight-year break between the kindergarten and middle-school vaccine boosters, and since we now surmise that the acellular vaccine lasts only about three years in an outbreak environment, 2010 represents the time when even fully immunized 8–12 year-olds were quite susceptible to getting the illness.

Since Marin has multiple dense clusters of unimmunized and underimmunized children, a single endemic pertussis case in the right community can start a big cluster of cases. Because schoolchildren spend time together mainly with their age peers as playmates and schoolmates, once a few 8–12 year-olds have pertussis, the whole cohort gets the illness easily even if up to date on their shots. That is exactly what happened in Marin in 2010. The unimmunized were the spark, and the fully immunized but susceptible preadolescents were the kindling and the fuel.

If our data were true outside Marin, they would predict outbreaks in other states in the same manner, more likely earlier in those with a lower vaccination rate, but eventually in all states. Washington State, Minnesota, Wisconsin and New York have all seen significant outbreaks in the last 18 months, thus proving the point. Thus far in 2012, more than 40 states have reported at

least twice the rate of pertussis than in the recent past.

Scientific evidence of waning pertussis immunity keeps mounting. The CDC's own evaluation of the Minnesota and Washington outbreaks verifies the age distribution of these outbreaks and supports the proposition of waning immunity. In a rigorous case-control study independent of our own, the Kaiser Division of Research just reported in the *New England Journal of Medicine* that acellular pertussis immunity wanes about 47% per year after vaccination and is significantly decreased by three years after vaccination.[2] Australian data recently published in *JAMA* suggest that the reason for recent outbreaks was the lesser duration of protection from acellular compared to whole-cell pertussis vaccine.[3] Finally, our group just presented a follow-up study at the Infectious Diseases Society showing that the risk of getting pertussis if fully immunized appears to be more than eight times greater for those with five doses of vaccine if they received all acellular vaccine compared to those who had one or more whole-cell vaccines. The Tdap adolescent and adult boosters seem to lessen this risk, but they do not eliminate it. In other words, Tdap boosts the whole-cell vaccine more than the acellular vaccine.

So what does this all mean? The whole-cell vaccine is gone and is not coming back. Many policy arguments are currently being made. One thing is clear: everyone who is due for the pertussis vaccine according to the schedule should get it now, especially the Tdap. Vaccine refusal remains a risk to all of us. The Advisory Committee on Immunization Practices (the vaccine-recommending body for the CDC) has recognized the validity of the evidence on waning acellular pertussis immunity and is now recommending boosting the Tdap immunization for every pregnancy a woman has, regardless of past vaccinations.

After that, policy opinions diverge. Some argue for more frequent child and adult boosters to avoid the susceptibility window. Most agree that we need to develop a better and more durable vaccine using 21st century vaccine technology. Others suggest more modest changes, such as targeted vaccine programs for when outbreaks begin or just targeting families with or about to have babies, also known as "cocooning."

One other problem might make employers and adult-medicine providers worried: what I call the "adult morbidity conundrum." That conundrum is the result of a long chain of events, beginning with the initial development of pertussis vaccine to eliminate infant mortality from pertussis. The vaccine also happened to lessen the whole community's disease burden of non-lethal older childhood and adult cases—but that was 80 years ago. Times have changed. We still wish to avoid pertussis mortality, but adult morbidity may be altogether different.

In the 1930s, most adults likely had some natural immunity to the highly prevalent childhood illness of pertussis. While natural immunity is not fully protective, it does attenuate the illness. The children of these adults received whole-cell vaccine and had fairly prolonged protection from pertussis, along with likely attenuation of later cases in adulthood. Up until the last 15 or so years, this fact held true for older teens and adults.

Now we are seeing the first cohort of youngsters entering adulthood never having received whole-cell vaccine or natural immunity. Fast-forward 10 years. Imagine that a 25-year-old with a bad cough walks into his office cubicles with a bunch of other fully vaccinated but susceptible peers (unless they were recently pregnant and boosted). Imagine he has pertussis. Will the susceptible cohort just be transferred to older ages? Might there be unmitigated pertussis with 100 days of untreatable cough causing huge work loss and economic woes for individuals and workplaces? What happens when they return home to recover near their newborns? We do not know.

We have to consider that not providing sufficient vaccine immunity to the future adult cohort that has never received whole-cell vaccine might be creating outbreaks in adults of greater severity and duration than seen in the past. The objectives of the pertussis vaccine nowadays may not only be prevention of infant death, but also prevention of adult morbidity.

Whooping cough is not yet a thing of the past. ◇

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Helping Kids Breathe Easier

Schuman Tam, MD

Asthma is a chronic respiratory disease characterized by inflammation of the airway and manifested as wheezing, dyspnea and/or cough. According to the National Center for Health Statistics, pediatric asthma prevalence increased steadily in the decade beginning in 1999 from 108 to 138 cases per 1,000.[1] In 2011, an estimated 9.6% of children aged 0–19 had asthma. The prevalence of asthma is higher in male children, a pattern opposite of that reported in adults. About 40% of pediatric asthma patients had at least one asthma attack during the previous 12-month period. In 2008, children aged 5–17, with at least one asthma attack in the previous year, were reported to have missed 10.5 million school days in the previous year. Childhood asthma is thus a common, disabling and potentially life-threatening chronic condition.

The National Heart, Lung, and Blood Institute helped develop two asthma research networks in the 1990s: the Asthma Clinical Research Network (ACRN) and the Childhood Asthma Research and Education (CARE) Network. The two networks provided a mechanism for an evidence-based approach for evaluating and treating bronchial asthma. The result of these efforts was the National Asthma Education and Prevention Program (NAEPP) guidelines. The most recent guidelines were published in 2007. The next guidelines will likely be based on new data generated by the two research networks. This article discusses the studies that shaped the 2007 NAEPP guidelines and examines recent published studies that likely will shape future care of asthma patients.

Dr. Tam, a clinical professor at UCSF, is an asthma and allergy specialist at the Asthma & Allergy Clinic of Marin & San Francisco.

In the early 1990s, considerable controversy existed regarding the safety of using regular short-acting beta agonists for asthma. The Beta Agonist Study (BAGS), published in 1996, showed that using 2 puffs of albuterol 4x per day was neither beneficial nor harmful compared to albuterol usage on an as-needed basis.[2] The authors concluded that inhaled albuterol should be prescribed for patients with asthma on an as-needed basis. The limitation of this study was that the subjects were primarily adult patients. The NAEPP incorporated the study findings into its recommendation that as-needed usage of short-acting beta agonist was essential.

In the late 1990s, it was reported that adding salmeterol, a long-acting bronchodilator, to patients who were on inhaled steroid was more effective than increasing the inhaled steroid dose. The Salmeterol or Corticosteroid Study (SOCS), published in 2001, showed that for asthma patients 12 to 65 years old who were controlled on inhaled steroid, switching to long-acting bronchodilator alone or to placebo alone resulted in more frequent treatment failures and exacerbations.[3] The authors concluded that it was inappropriate to use long-acting bronchodilator alone without inhaled steroid. Performed in parallel to the SOCS trial was the Salmeterol +/- Inhaled Corticosteroid (SLIC) trial, also published in 2001.[4] This study of patients with moderate asthma showed that the addition of a long-acting bronchodilator to inhaled steroid allowed up to 50% reduction in inhaled steroid dose; however, the inhaled steroid could not be eliminated without loss of asthma control.

Prior to 2006, it was unknown whether inhaled steroid could modify subsequent development of asthma. To address this question, the CARE network conducted its first trial: the Prevention of Early Asthma in Kids (PEAK).[5] This 3-year-long trial studied 2–3 year olds with positive asthma predictive index. One group was treated with fluticasone 88 mcg 2x per day and another group with placebo 2x per day. After 2 years, treatment was stopped, and subjects were observed the following year. During the 2-year active treatment period, usage of inhaled steroid was associated with a higher proportion of asthma-free days, fewer exacerbations, and a reduced need for supplemental controller medications. During the observation year, after treatment was stopped, there was no significant difference between the groups in asthma-free days, exacerbations or pulmonary function. The authors concluded that children with a high probability of persistent asthma did better in terms of asthma control while actively receiving steroid; but that benefit disappeared soon after the

steroid was stopped, and compared to placebo, there was no improvement in lung function. The early usage of inhaled steroid did not have a disease-modifying effect after 2 years, and such usage was unable to alter the natural history of asthma in high-risk preschool children.

The two common controller medications for mild persistent asthma are inhaled steroid and leukotriene modifier. To compare these medications, the CARE network in the early 2000s conducted the Characterizing the Response to a Leukotriene Receptor Antagonist and an Inhaled Corticosteroid (CLIC) trial.[6,7] This randomized crossover trial compared the responses of patients aged 6 to 17 with mild to moderate asthma treated for 2 months with inhaled steroid, fluticasone 100 mcg bid x 2 months, with an age-appropriate montelukast dose administered, resulting in a greater than 7.5% improvement of FEV1. Seventeen percent of the subjects responded to fluticasone or montelukast; 23% responded to fluticasone alone; 5% responded to montelukast alone; 55% responded to neither medication. When other asthma clinical measures were considered, improvement was significantly higher with inhaled steroid treatment than with montelukast treatment.

The CLIC findings support the NAEPP guidelines' preference of inhaled steroid as first-line therapy for mild to moderate persistent asthma in children. It is also important to remember that 5% of the asthmatic children responded to montelukast and not fluticasone. Therefore, asthmatic patients are heterogeneous, and not all patients respond to one medication. If a patient is not responsive to inhaled steroid, it is appropriate to try an alternative, such as leukotriene modifier.

To further confirm the effectiveness of inhaled steroid, to compare effectiveness between inhaled steroid and leukotriene modifier, and to study the effect of adding a long-acting bronchodilator, the CARE network in 2002 conducted the Pediatric Asthma Controller Trial (PACT) in asthmatic subjects 6–14 years old, with mild persistent asthma.[8] This trial allocated subjects into 3 groups: 1) fluticasone 100 mcg bid; 2) fluticasone 100 mcg qAM and salmeterol 50 mcg bid; 3) montelukast 5 mg qPM.

Group 1 and Group 2 had similar patient-measured outcomes, including percentage of asthma control days and prevention of asthma exacerbations. Group 1 (inhaled steroid only) was superior to Group 3 (montelukast) for asthma control outcomes, including asthma control days and improvement of lung function. Similar to the CLIC study, inhaled steroid was more effective than leukotriene modifier. Similar to the SLIC trial, the PACT trial showed that addition of long-acting bronchodilator in group 2 with half the dose of inhaled steroid, as compared to group 1, could achieve similar asthma control days and improvement of lung function.

In summary, inhaled steroid is statistically more effective than leukotriene modifier, and the addition of long-acting bronchodilator to inhaled steroid may allow practitioners to use a lower dose of inhaled steroid to achieve the same asthma control.

The Childhood Asthma Management Program (CAMP) research group, which conducted a prospective study to investigate the effectiveness and safety of inhaled steroid, reported the results in 2000 and issued a follow-up report in September 2012.[9,10] In late 1993, 1,041 children aged 5–12 with mild to moderate persistent asthma were recruited and randomized to 3 groups: 1) 200 mcg budesonide inhaling bid; 2) 8 mg nedocromil inhaling bid; 3) placebo. Subjects were treated for 4–6 years with the respective drugs and placebo.

After 4 years of active treatment, neither budesonide nor nedocromil were better than placebo in terms of lung function as measured by post-bronchodilator FEV1. Post-bronchodilator FEV1 is a measurement of fixed airway obstruction; therefore, percent-predicted post-bronchodilator FEV1 over time indirectly and non-invasively measure airway remodeling. Neither inhaled budesonide nor nedocromil attenuated airway remodeling compared with placebo. The inhaled budesonide group, however, had better control of asthma than the placebo and nedocromil groups.

Similar to the PEAK trial in younger children, the initial findings for the CAMP trial showed that inhaled steroid could not alter the natural history of asthma, namely airway remodeling with progressive loss of lung function. During active treatment, inhaled steroid was better than placebo for asthma symptom control. Subsequent analysis of the data showed that there was a subgroup (about 25%) among the 1,041 children who seemed to have a more rapid decline in post-bronchodilator FEV1.[11] Therefore, about 25% of the asthmatic children might have progressive deterioration of lung function. Inhaled steroid is unable to revert this natural course, although it can reduce asthma symptoms and exacerbation during treatment. An international study called START also confirmed the finding that inhaled steroid was unable to prevent deterioration of lung function.[12]

Prior to the 13-year follow-up of the CAMP trial, it was generally believed that children who received inhaled steroid were able to achieve adult height. One study concluded that reduction in growth velocity was transient during the early phase of initiation of inhaled steroid.[13] This study, however, was based on a small control group—not on a direct comparison between an inhaled steroid group and a control group.

Investigators in the CAMP trial performed a study on their cohorts 13 years after the 4-year treatment with inhaled steroid, inhaled nedocromil and inhaled placebo.[10] During the 13-year period, the patients were treated by their primary physicians per NAEPP under advisement from CAMP physicians. Follow-ups were done at the CAMP study centers for height and weight measurements 2x per year for the first 4.5 years, and 1x year for the

next 8 years. Up to 90% of the original cohorts were successfully retained for measurement of height at adulthood.

Mean adult height was 1.2 cm lower in the group treated with budesonide initially than the group treated with placebo. The initial reduction in growth during the 4-year treatment period during childhood was 1.2 cm, and that reduction persisted into adulthood. It appeared the difference in growth seen in the first two years of assigned treatment in the budesonide group, as compared with placebo group, was primarily among prepubertal participants 5–10 years old.

When treating pediatric asthma patients, practitioners have to weigh the potential growth-reduction side effect with the well-established efficacy of inhaled steroid in controlling persistent asthma. It is appropriate to use the lowest effective dose for symptom control in order to minimize concern about the effects of inhaled steroid on adult height.

The 2007 NAEPP guidelines,[14] driven by data generated by the ACRN and CARE networks, provide a good knowledge base for physicians to follow in treating their asthma patients. It is clear that inhaled steroids are effective in controlling persistent asthma, but not in altering the natural history of asthma—namely progressive deterioration of lung function in certain subgroups of patients with persistent asthma. The daily use in children, especially from ages 5 to 10, can result in a reduction of growth during the first two years of use, and the resulting difference in height persists into adulthood. Therefore, the recommendation of the NAEPP Guideline is appropriate: obtain control, then step down to the lowest dose possible to reduce the risk of the controller medication.

There are many unanswered questions in caring for pediatric asthma patients. In adult asthmatic patients, evidence based on the IMPACT trial and the more recent BASALT trial demonstrated that intermittent usage of inhaled steroid based on symptoms was similar to daily usage of inhaled steroid in patients with mild to moderate asthma.[15,16] Can this same principle be applied to pediatric asthma patients? We need studies similar to the IMPACT and BASALT trials to answer that question. Such studies may help reduce inhaled steroid usage in pediatric asthma patients; they may also become the basis for changes in treatment guidelines for mild persistent asthmatic patients.

Similarly, the adult TALC trial showed that addition of tiotropium inhaler to inhaled steroid was not inferior to adding salmeterol to inhaled steroid in treating adult patients with moderate persistent asthma.[17] Another recent finding is that adding tiotropium to patients on inhaled steroid and long-acting bronchodilator could improve asthma control by reducing the chance of an exacerbation and by improving bronchodilation.[18] We need studies of tiotropium in pediatric asthma patients, which again may help to reduce inhaled steroid usage.

Until the next NAEPP guideline update is available, practitioners should also become familiar with the recent data generated by the CARE network, the ACRN network and the CAMP research group in order to generate appropriate treatment plans for their patients. ◇

Phone for Dr. Tam: 415-461-8909

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You Simply Need To Pick Up the Phone

Cyndy Doherty and Paula Robertson

The trial is over. Jerry Sandusky, former assistant football coach at Penn State, has been convicted of serial child molestation. The university will be paying millions of dollars in fines. We may come away feeling vindicated, but we also know in our hearts that this horrendous behavior is continuing elsewhere. Almost nobody knows where. But as in the cases at Penn State, someone *does* know—and isn't reporting.

There was evidence through the years of child abuse at the hands of Jerry Sandusky. A temporary employee notified another staff member—but that staff member didn't report the abuse. An assistant coach notified his supervisor, but that supervisor chose the reputation of the university football program over the emotional and physical health of defenseless boys. Only through the repeated efforts of one very determined mother did the authorities finally act. She made a report that stopped the abuse.

Here in Marin County, we often hear, "Well, there's no child abuse in Marin County." How could there be child abuse in the shadow of beautiful Mount Tam?

Unfortunately, the statistics tell another story. In 2006, Marin County Children and Family Services received 2,122 calls of suspected child abuse. In 2011, they received 1,986 calls. At first glance, it appears that child abuse is on the decline—*but the number of calls that required an immediate response went up by 9%*. Child welfare professionals can't be absolutely sure, but we believe that as the economy declines, the severity of child abuse increases.

The Marin statistics also prompt a troubling question. Could the decrease in the number of child-abuse calls indicate not that child abuse has gone down, but that those who suspect abuse are not reporting it, as in the case of Penn State?

The effects of child abuse and neglect on the developing brain are chilling. A recent study by Dr. Bruce Perry found that when infants and small children are exposed to violence and trauma, their brains don't develop the same way as children who are being reasonably nurtured.[1] According to Perry, the results are long-lasting. Children who were born with every chance of hope and success but then are abused are no longer able to compete. Their brains develop differently simply because they are exposed to the trauma of violence and neglect. They may never have the chance to reach their full potential.

The classic Adverse Childhood Experience (ACE) study by Dr. Vincent Felitti is equally startling.[2] He found that children exposed to adverse childhood experiences (trauma, abuse, neglect, domestic violence, poor parental mental health) were more apt to suffer chronic illness in their adult years. Those with the highest exposures to adverse experiences in childhood had significantly higher rates of diabetes and heart disease than the control group. Drug and alcohol use, liver disease, domestic violence, suicide—all increased in direct proportion to the number of adverse experiences the subject had in his or her childhood.

We can do better.

The first child abuse and neglect reporting law in the United States was enacted in 1963. It applied only to physicians. The law assumed that when a physician suspected abuse, he or she would call the authorities. As time went on, the safety net for reporting abuse was enlarged to include child-care workers, teachers, nurses, therapists, firefighters, police, and many other professionals. But the law doesn't work if we don't report.

Making a report of child abuse is hard. People are always hesitant to make reports. Did they really see or hear what they thought they saw or heard? Is their report going to make things better or worse? People who make child-abuse reports on a regular basis still hesitate. We have all been trained since childhood not to be snitches—but you just might change the course of a child's life if you do make a report. Making a report starts the wheels in motion to provide resources and services, not only to the child, but also to the family.

A few years ago, one Marin pediatrician chose to make a report. (Details of this and the following case have been changed.) The doctor reported serious concerns about a little girl

Ms. Doherty is executive director of Marin Advocates for Children. Ms. Robertson is a program manager at Marin County Children and Family Services.

who was dangerously below normal in both height and weight. Her mother was from another country and was struggling to understand American language and culture. Because that doctor picked up the phone and reported his concerns, Marin County Children and Family Services (CFS) intervened. The child was placed briefly with a family member while CFS gave the child's mother support and training in her own language about parenting and nutrition. Once CFS staff were confident that the mother was capable of caring for her daughter, they returned the child to her and provided the family with a professional parenting partner, who continued to teach the mother how to parent and nourish her daughter more effectively. The child is now in the normal range and is thriving. Where would that child be if the pediatrician had not picked up the phone?

In another instance, an ER doctor made a report about a 9-month-old boy with a suspicious fracture of the femur. Full skeletal x-rays showed that the child had five fractures in various stages of healing. As often happens in these cases, it was impossible to determine exactly how these injuries occurred. CFS offered the family various services to help them understand how to handle an active and developing baby, but the family refused. The child was subsequently adopted into a home where he is now thriving. What would have happened to that baby if the doctor had not picked up the phone?

The law is clear. Physicians are legally mandated to make reports of suspected abuse. That means the doctor does not have to be sure: he or she just has to have a suspicion that a child is suffering from abuse or neglect. The penalties for *not* making a report including fines and jail time. But those penalties pale in comparison to the idea that a child might suffer unspeakable pain because someone hesitated to pick up the phone.

The Marin County CFS hotline is **415-473-7153.** Call it if you suspect abuse, or even if you simply want to discuss your concerns with a social worker trained to handle these situations. You don't have to be sure. You simply need to pick up the phone.

We encourage every doctor in Marin County to know the facts about child-abuse reporting. If you would like to attend a mandated-reporter training session or would like to set up a class in your clinic or hospital, please contact Cyndy Doherty at 415-507-9016 or cyndy@marinadvocates.org.

Know the facts. Make a difference in a child's life. ◇

Emails: cyndy@marinadvocates.org, probertson@marincounty.org

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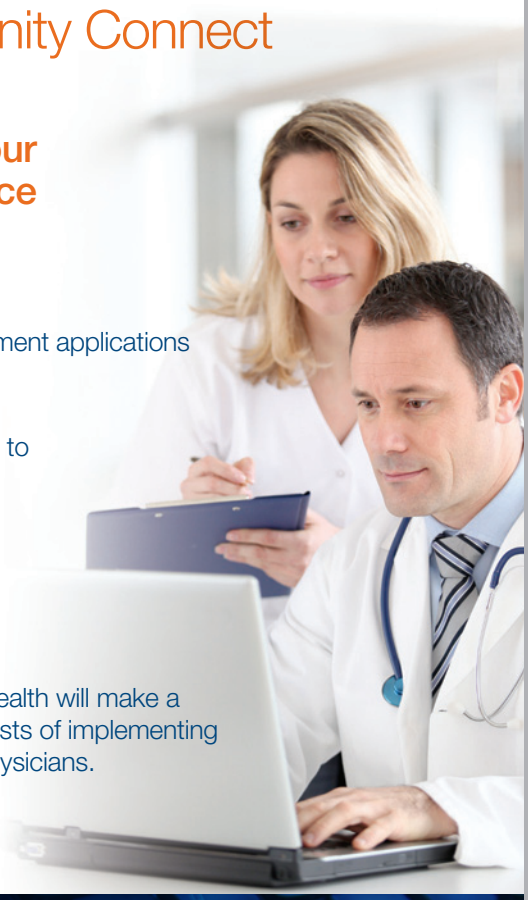

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In this issue:

Aetna to require additional accreditation requirements in order to be paid for certain surgical pathology services ____ 1
Update on two Anthem Blue Cross issues pending with the Department of Managed Health Care ____ 1
Meet Your CMA Center for Economic Services Advocate: Mark Lane ____ 2
CMA Advocacy at Work ____ 2
Urgent survey response requested ____ 3
Aetna erroneously terminates providers from California network ____ 3
Document, Document, Document ____ 3
United Healthcare announces extension of HIPAA 5010 enforcement ____ 4
What's a CONS? ____ 4
Save the Date ____ 4
Act now to avoid the 2013 e-prescribing penalty ____ 5
Payor Updates ____ 5
Health plan provider newsletters ____ 5

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Aetna to require additional accreditation requirements in order to be paid for certain surgical pathology services

Aetna recently notified physicians that, effective August 1, 2012, practices performing in-office pathology testing will be required to be both Clinical Laboratory Improvement Amendments (CLIA) certified and accredited with the College of American Pathologists (CAP).

In a letter to physicians, Aetna claims that the change is consistent with the Centers for Medicare & Medicaid Services (CMS) recognition of CAP as an approved accreditation organization for non-hospital anatomic pathology testing.

The California Medical Association has voiced concerns with the implementation of this policy and has asked Aetna to explain the need for dual certification. Although CMS may recognize CAP as an approved accreditation organization, CMS does not require both a CLIA certification and a specialty society accreditation to perform in-office pathology testing services. Further, CMA expressed concerns with the ability of physicians to obtain the CAP accreditation prior to the deadline imposed by Aetna. According to CAP, the accreditation process takes approximately 90 days. Additionally, the process of obtaining a secondary accreditation can be very costly for practices.

In addition to their contact with Aetna on this issue, CMA is working closely with the American Medical Association (AMA) and several other state and specialty medical societies. Stay tuned for further details.

Practices with questions about the letter can contact Tammy Gaul, senior network manager at Aetna at (215)775-6604.

Contact: CMA reimbursement help line, (888) 401-5911 or mlane@cmanet.org

Update on two Anthem Blue Cross issues pending with the Department of Managed Health Care

DMHC claims audit

As previously reported, on Jan. 12, 2012 the Department of Managed Health Care (DMHC) ordered Anthem Blue Cross to reprocess provider claims, with interest, dating back to 2007.

The order is based on 2008 DMHC audits of the seven largest health plans in California. These audits found violations of claim payments above the threshold allowed under California law at all seven health plans.

As a result, DMHC assessed administrative fines, required the plans to pay providers the money they were owed and mandated that plans demonstrate

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Hobbies—You Asked About Hobbies?

Joan Pont, MD

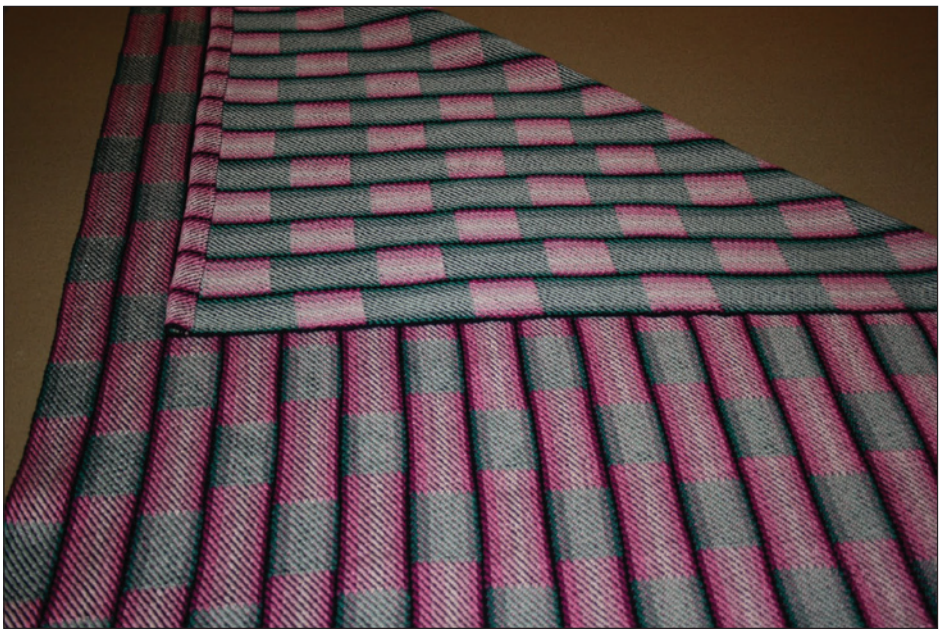
Why do I pick hobbies that have the same (long) learning curve as medicine itself? Take weaving cloth, for example. People have been weaving for thousands of years. It is technologically demanding, takes a lot of equipment, your first few hundred attempts look like crap, and yet I persevere. Crazy, no?

For just a peek at what is involved with weaving sturdy enough cloth to go into a washing machine and dryer, there are about a thousand steps. Literally. Take my last project. Cut 1,296 lengths of yarn, three yards each, assorted in eight different colors. Wind these "warp" (longitudinal) threads on a loom around a roller called a warp beam. Then thread each end through a heddle, a piece of wire or string with an eye in the middle. The heddles on my loom are arranged on 16 different shafts. That represents one thousand two hundred ninety-six times when one can make a boo-boo. Mistakes jump out at you in the finished cloth like a run in a nylon stocking.

Then comes the traditional weaving part. You may have walked past someone weaving at a Renaissance Fair or lifestyle museum or an actual weaver earning their living doing their work. Lifting one or more heddles separates the warp threads, and cre-

Dr. Pont, an internist, is an assistant physician in chief at Kaiser San Rafael.

Warping or "dressing" the loom by arranging all the warp ends through their heddles.



Pink and green saddle blanket, double-faced twill, cotton.

Dr. Pont riding her Holsteiner mare, U-Princess, over a 3-foot jump at the Leone Equestrian Center horse show in Sacramento, April 2012.

ates a "shed" (the vertical space between the raised and unraised warp threads). The weaver throws a shuttle with the "weft" (transverse) thread through the shed, beats it down snugly with the "reed" (a comb-like apparatus), and repeats 1,296 times per yard.

I do not even think about the thousands of times I throw the shuttle. Definitely more throws than Matt Cain in a Giants game. Throwing the shuttle is like breathing. Do you think about how many breaths you took today?

Then comes the exaltation of completion. You can create something no one, in the thousands of years of human activity, has come up with before. My creations are unique, somehow satisfying, and they transport me to another century. Not that the other century was an easier or simpler time. They might not have had Medicare coding challenges, but they did have to store enough food to get from harvest to harvest and to avoid the Black Plague and various other epidemics.

I feel like I am working alongside all the previous weavers who ever lived and can build on their legacy to create new material. Literally, material.

I am coming to realize that I can learn nothing new; I am just recycling skills learned as a child. I was introduced to weaving when I was 12 years old by an awesomely nice neighbor who was a treasure and a talent.

My other hobby, riding horses, started even earlier, when I was 6 years old. Probably unsafe—no protective headgear in those days. I can only guess what my social-climbing mother was planning when she set out on this adventure. A Cold War aerospace engineer by day and horse-show mother by night. What was she thinking? That I would meet Prince Rainier and be asked out hunting? Oh well, for whatever crazy intentions she had, the passion stayed with me.

I rode from 6 to 18 years of age, riding upwards of 200 different horses and competing in three-day eventing, hunting, jumping and medal classes. I always thought I was terrible. Two people I trained with were Suzy Hutchison and Hap Hansen. Both went on to international careers, winning hundreds of Grand Prix jumping events each. My hat is off to each of them.

As college-bound kids do, I quit for a mere 35 years. Then, in 2007, a colleague asked, "Why don't you ride again?" Ridiculous, I thought. After a 35-year gap, there is nothing left. But tempted, I signed up for some lessons. After five lessons, I again felt more comfortable sitting on a horse than sitting on a chair, more normal, more centered. I climbed back to a faint resemblance of high school-era ability through plenty of practice and hard work. Three days a week, five years later, this is what we look like: little jump, big dreams. ◇

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Novato Community Hospital

Ralph Koenker, MD

Federal health care reform is at its core a program of initiatives intended to help physicians, hospitals and other caregivers improve the safety and quality of patient care while making it more affordable. Since our fall 2011 update in *Marin Medicine*, Novato Community Hospital (NCH) has been extremely active in supporting the values of the Patient Protection and Accountable Care Act, strengthening our outpatient programs, and continuing our focus on clinical quality and patient satisfaction.

This past summer, NCH applied to The Center for Medicare and Medicaid Innovation (CMMI) to participate in the Bundled Payments Care Improvement Initiative. Different from Accountable Care Organizations that are designed to manage population-based health outcomes, Bundled Payment is for delivery of acute episodic care. The approach combines payments for hospital, physician and other provider services during a 30-, 60- or 90-day care episode into a single bundled payment, resulting in improved care coordination and patient outcome monitoring among partnering providers.

The hospital's proposal, which focused on lower extremity joint replacement, was recently selected by CMMI to progress to the next stage of the application process required to launch a three-year program. The proposed project is consistent with the hospital's commitment to providing high quality, affordable services to the community by strengthening our relationships with physicians and community providers. We look forward to the opportunity to redesign care pathways and improve efficiency with these partners as we work through the final stages of the CMMI application and the project implementation process.

Sutter Physical Therapy & Sports Fitness—located in the Terra Linda Health Plaza in San Rafael—is among the outpatient services operated by the hospital that will play a key role in the Bundled Payment program. Our program specializes in sports injury treatment and prevention, as well as individualized post-surgery plans designed to safely return patients to their former activities as soon as possible. The program is always looking for ways to fill unmet community health needs.

To that end, physical therapist Lucia Miller, MPT, recently began offering pelvic physical therapy at Physical Therapy & Sports Fitness. The National Institutes of Health estimates that one-third of women in the United States will develop a pelvic floor disorder in their lifetime.

"Physical therapists are experts in treating the musculoskeletal system, which includes the pelvis," said Miller. "Pelvic physical therapy is a largely underserved need in health care. Many people—from teenagers to seniors—silently and unnecessarily suffer from pelvic pain and other treatable problems." Miller's strategies include individual assessment, treatment, education and free introductory classes.

Engaged, committed, expert clinicians like Lucia are the reason that NCH delivers best in Marin Patient Satisfaction scores as measured by the national HCAPS (hospital consumer assessment of healthcare providers and systems) survey sent to patients after discharge. NCH scores demonstrate our physicians' and staff's commitment to the patient care experience. For 2011, we were the only Marin County provider with 10 of 10 ratings above the California average.

All hospitals are required to participate in the HCAPS survey, and the results are reported on the Hospital Compare website at www.hospitalcompare.hhs.gov. Anyone can view up to three hospitals' performance results side-by-side. Medicare will use these measures to determine reimbursement for acute care beginning in 2013.

NCH medical staff can be found actively participating in all of the activities and initiatives mandated by the Patient Protection and Affordable Care Act. In many areas, they are leading the charge to help other caregivers improve the safety and quality of patient care while making it more affordable. Their enthusiasm for improvement is contagious. The physicians' value as role models and team builders cannot be overstated. It is the key to our success as we continue on this journey. ◇

Dr. Koenker, a diagnostic radiologist, is chief of staff at Novato Community Hospital.

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HOD 2012

CMA delegates set policy at annual meeting

More than 700 California physicians convened in Sacramento October 13-15 for the 2012 House of Delegates (HOD), the annual meeting of the California Medical Association (CMA). Each year, physicians from all 53 California counties, representing all modes of practice, meet to discuss issues related to health care policy, medicine and patient care and to elect CMA officers.

by Elizabeth Zima and James Noonan

Over 120 resolutions were introduced and debated in reference committees on Saturday, October 13, 2012. Over the next two days, the complete house met again to debate and vote on reference committee recommendations. A total of 97 resolutions were adopted.

The debates were passionate, polite and sometimes humorous. For example, during a debate on the health hazards of sitting, one speaker suggested that the House stand for the rest of the debate. In another instance, during a contentious debate on whether to support nurse practitioners' ability to sign POLST forms, the debate was interrupted so that former CALPAC chair, and newly elected CMA president-elect Richard E. Thorp, M.D., could have his mustache shaved off by his wife – part of a fund-raising challenge.

On Sunday the House elected new officers, including Sacramento pediatrician, Paul R. Phinney, M.D., as the 2012-2013 CMA President, and the now clean shaven Dr. Thorp as president-elect. The rest of the CMA Executive Committee were affirmed by the HOD, including the immediate past-president, James T. Hay, M.D., speaker, Luther F. Cobb, M.D., vice-speaker, Theodore M. Mazer, M.D., board chair, Steven E. Larson, M.D., and board vice-chair, David H. Aizuss, M.D.

The following are summaries of some of the resolutions that were adopted as policy.

House of Delegates 2012

Revised blood donor deferral criteria

(Resolution 108-12)

The delegates expressed support for the use of rational, scientifically-based deferral periods for blood donations, applied based on level of risk rather than on sexual orientation.

Awareness and prevention of bullying

(Resolution 113-12)

The delegates called on CMA to support awareness and prevention of bullying in all its forms and to support the development of family, school and community programs and referral services for victims and perpetrators of bullying.

AB 32 and California's clean air leadership

(Resolution 117-12)

The delegates voted that CMA should support implementation of the California Global Warming Solutions Act of 2006, which protects the health of Californians from climate change.

Safer furniture flammability standards

(Resolution 125-12)

The delegates asked that CMA endorse a revision of the California TB 117 furniture flammability standards, which would not require harmful flame retardants yet provide more effective fire safety using barrier technology and flame resistant fabric covers.

Support for amending the affordable care act

(Resolution 201-12)

The delegates directed CMA to support amending the Affordable Care Act to address issues of concern to the practice of medicine.

Dual eligible monitoring and reporting

(Resolution 208-12)

This resolution directs CMA to collect data from its membership regarding difficulties with the planned transition of dual eligibles to managed care plans and to report the findings to the California Department of Health Care Services, the California Department of Managed Health Care and the federal Centers for Medicare & Medicaid Services.

Electronic prescribing and EHR payment reductions

(Resolution 214-12)

The delegates voted to oppose financial penalties by any payor for physicians who do not adopt health information technology, such as electronic medical records and electronic prescribing.

Health care equality for same-sex household members

(Resolution 505-12)

The delegates voted to recognize that denying civil marriage contributes to poorer health outcomes for gay and lesbian individuals, couples and their families. The resolution also calls on CMA to support measures providing same-sex households with the same rights and privileges to health care, health insurance and survivor benefits afforded to opposite sex households.

Pharmacist's substitution of physician prescriptions

(Resolution 507-12)

The delegates asked that CMA consider legislation to make it illegal for pharmacists to receive financial incentives to substitute a physician's prescription.

Increasing utilization of POLST orders

(Resolution 512-12)

The delegates approved a resolution that calls on CMA to support awareness and use of Physicians Orders for Life-Sustaining Treatment (POLST) forms by physicians in all appropriate instances where medical services are provided to patients at the end of life.

HIPAA and medical record accessibility

(Resolution 606-12)

The delegates asked CMA support a study on the extent to which HIPAA laws impede the timely transfer of medical information necessary for the appropriate coordination of care.

Helping physicians improve their health

(Resolution 610-12)

The delegates voted to encourage all physicians and physicians-in-training to properly manage their own physical and mental health and to serve as exemplars of healthy behaviors.

The complete and final actions of the 2012 House of Delegates are available to members at www.cmanet.org/hod under "Documents."

Sacramento pediatrician elected CMA president

Sacramento physician Paul R. Phinney, M.D., was installed as the 145th president of the California Medical Association (CMA) during the organization's annual House of Delegates held in Sacramento October 13-15.

Dr. Phinney is a pediatrician at Kaiser Permanente and has been a member of CMA since 1988. He has served in a number of leadership roles, including president-elect, chair of the CMA Board of Trustees and previously served on the CMA Council on Legislation and on the CMA Political Action Committee (CALPAC) Board of Directors.

Addressing the group of nearly 1,000 physicians, residents, medical students and others on Sunday, Dr. Phinney challenged his colleagues to lead change rather than succumb to the "default future."

"We owe it to the public and to our profession to be leaders in health care reform – to create a better future that we help invent," he said to the crowd.

"We live in turbulent and uncertain times that very likely will produce the most rapid change in the delivery of health care that the nation has seen in decades, and I look forward to tackling those challenges head on in my term as president," concluded Dr. Phinney.

Speaking to his goals for the next year, Dr. Phinney acknowledged the next generation of students entering medicine. "Mentorship deserves our attention, and will be an area of my focus over the next year. A healthy future requires up-front investment," he said.

Dr. Phinney's complete address to the delegates can be watched on CMA's YouTube channel, www.youtube.com/cmaphysicians.

Also serving on CMA's 2012-2013 Executive Committee are:

- Immediate Past President James T. Hay, M.D., a San Diego family physician
- President-Elect Richard E. Thorp, M.D., an internal medicine physician in Paradise
- Speaker of the House Luther F. Cobb, M.D., a surgeon in Humboldt County
- Vice Speaker of the House Theodore M. Mazer, M.D., a San Diego ear, nose and throat specialist
- Chair of the Board of Trustees, Steven E. Larson, M.D., an internist and infectious diseases consultant in Riverside County
- Vice Chair of the Board of Trustees, David H. Aizuss, M.D., a Los Angeles ophthalmologist

CMA says denial of civil marriage to same sex couples has negative health impact

On Sunday, October 14, 2012, the California Medical Association (CMA) House of Delegates passed a resolution calling for health care equality for same sex households. Hundreds of physician representatives from across the state voted to support a resolution that states "denying civil marriage contributes to poorer health outcomes for gay and lesbian individuals, couples and their families."

In written testimony, the sponsors of the measure, the CMA Residents and Fellows Section, said, "legal protections afforded to same-sex couples are crucial given that marriage is a strong predictor of health insurance in the U.S. In particular, women in same-sex households tend to have less health insurance than woman in opposite-sex households.

"As a consequence, children in same-sex households lack the protections of health insurance afforded by marriage," the document continues. "Having health insurance does not provide same-sex couples with the financial and legal protections that married couples receive. Same-sex couples are not covered by the protections of COBRA or the Family and Medical Leave Act. Same sex couples are also not typically recognized as family by blood or marriage and are denied the right to make surrogate health care decisions for their loved ones."

The resolution **(505-12)** would also require CMA to work to reduce health care disparities among members of same-sex households, including minor children. It also calls on CMA to support measures providing same-sex households with the same rights and privileges to health care, health insurance and survivor benefits afforded by opposite-sex households.

CMA delegates call for increased advocacy on duals transition

Recognizing the challenges that California's planned shift of Medicare and Medi-Cal dual eligible patients to managed care plans will pose to patients and the physicians that serve them, the California Medical Association (CMA) has adopted policy to help keep physician concerns in clear view of the agencies orchestrating the transition.

The policy **(Resolution 208-12)**, which was adopted at the CMA's annual House of Delegates meeting, calls on the association to collect data from its membership regarding difficulties with the planned duals transition and, if difficulties are found to be widespread, report them to the California Department of Health Care Services, the California Department of Managed Health Care and the federal Centers for Medicare and Medicaid Services.

During the floor debate regarding the issue, delegates noted that the state's Coordinated Care Initiative, which includes a pilot program to passively enroll patients eligible for both Medicare and Medi-Cal in eight of California's largest counties, would see more than 75 percent of the state's dual eligibles transitioned to managed care plans. The shift, speakers said, would likely lead to considerable confusion among patients and almost certainly interrupt relationships that have been established with their existing physicians.

Under the pilot program, patients will be enrolled in a managed care plan unless they actively opt out.

In addition to asking that CMA monitor the transition, the newly adopted policy also requests that the association advocate that the appropriate state agencies provide "full and clear disclosure" on options and consequences facing patients affected by the pilot program.

More information regarding the dual eligible transition can be found in CMA's online duals resource center, at www.cmanet.org/duals.

Delegates strongly oppose Medicare RAC audits

Members of the California Medical Association's (CMA) House of Delegates spoke out strongly against aggressive down-coding efforts being taken up by Medicare's Recovery Audit Contractor (RAC) firm, and have adopted policy that officially puts the association on record as opposing the practice.

The resolution, **222-12**, stems from an ongoing problem of an out-of-state auditing firm, Connolly Healthcare, selectively down-coding claims on behalf of Medicare, forcing physicians to undertake costly and time-consuming appeals.

The audits and subsequent down codes, which several speakers equated to financial "bounty hunting" on behalf of the Centers for Medicare & Medicaid Services (CMS), were almost always reversed upon physician appeal, which suggested that they were of little merit to begin with, speakers said.

"I can't tell you how outraged we doctors should be that this is going on," James Hinsdale, M.D., a past CMA president, said during the resolution's floor debate.

In addition to asking that CMA work to stop the audit practice, the resolution also requests that, if efforts to halt the practice are unsuccessful, CMA urge CMS to reimburse physicians who file successful appeals for the time and resources expended in the appeal efforts.

Successful passage of the resolution brought CMA in line with the American Medical Association's (AMA) position on the matter. AMA has been actively lobbying CMS to halt the recovery audits.

ACA topic of heated debate at House of Delegates

Since the passage of the Patient Protection and Affordable Care Act (ACA) in 2010, it's been a virtual certainty that delegates at the annual House of Delegates meeting would debate to influence policy regarding the landmark reform bill.

This year's gathering was no exception, as resolutions touching upon various aspects of the ACA were introduced, and in some cases, adopted as official California Medical Association (CMA) policy.
Of the resolutions introduced and debated over the weekend, it appears that Resolution 202-12 will produce some of the most immediate results.

The resolution, which deals with the California Health Benefits Exchange, asks that CMA support several actions that will help ease the transition of roughly 1.6 million new enrollees to the state's Medi-Cal program, as well as a list of requirements that will help protect physicians when contracting with plans offered through the exchange's online marketplace.

Specifically, the resolution asks that county and state funding sources that currently help provide care for medically indigent adults follow those individuals when Medi-Cal is expanded in 2014, and that the exchange takes a more active role in monitoring network adequacy of its offered plans.

The issue of network adequacy has already garnered a significant amount of attention from CMA staff, but an agreeable solution has yet to be reached with exchange leadership.

A separate resolution, **201-12**, reaffirmed CMA's position of continuing to work toward amending the ACA to "address issues of concern to the practice of medicine," and was adopted by the House.

Finally, two resolutions, **204-12** and **205-12**, launched the seemingly annual debate over single payor coverage in California.

During the reference committee hearings, supporters and opponents of single payor in California took to the microphone to voice their opinions on the matter, providing some of the most passionate and ideologically divided debate of the weekend.

Ultimately, reference committee members recommended that delegates disapprove both resolutions, noting that CMA has "well thought out and longstanding" policy on the issue of single payor. (CMA's Policy Compendium is available to members at www.cmanet.org/policies. The new policies passed this year will be added to the compendium soon.)

For more information on any of these resolutions, or general reform activities in California, please subscribe to CMA's regular reform newsletter, *CMA Reform Essentials* at www.cmanet.org/reform-essentials.

CMA debates resolution that calls on insurers to cover e-mail consultations

As advances in technology continue to redefine health care, the California Medical Association (CMA) is taking steps to bring the physician-patient relationship into the 21st century.

During the association's annual House of Delegates meeting, a resolution was introduced that would ask CMA to support legislation requiring insurance providers in California to include "telephone or other electronic patient management services" in their covered services, while also allowing physicians to bill patients directly for the provision of such services.

Currently, insurance providers are not required to cover consultations that occur via telephone or email, and physicians in most instances have no legal way of billing patients or payers for such services.

Throughout a lengthy period of floor debate, several

CALPAC fundraising record shattered at House of Delegates

CALPAC, CMA's political action committee, carried two things into the 2012 House of Delegates meeting – last year's three-day fundraising record of $110,000 and a fully mustachioed chair posing a challenge to delegates in attendance.

In the end, neither would emerge from the weekend unscathed.

In a record-setting show of support for CALPAC, CMA members contributed a total of roughly $152,000, besting last year's mark while also exceeding the $150,000 goal established before the House of Delegates.

Throughout the weekend, attendees were informed that, should the goal be met, outgoing CALPAC Chair and new CMA President-Elect Richard Thorp, M.D., would shave his moustache during the full house session held on Monday morning.

With the final tally confirmed, Dr. Thorp took to the stage to have his upper lip shorn clean by his wife, Vicki. (Check out the photos on CMA's facebook page, www.facebook.com/cmaphysicians.)

While the record breaking weekend was a House-wide effort, several counties, including San Diego, San Francisco and Santa Clara, were recognized for their outstanding participation.

The donations collected over the weekend, as well as all contributions made to CALPAC, will be used to support candidates who share medicine's agenda and priorities and will work to affect policies beneficial to the House of Medicine.

speakers noted that patients are becoming increasingly reliant upon remote interaction with their physicians, while insurers only cover services offered in a face-to-face setting, with few exceptions. If this does not change, speakers noted, physicians would be facing considerable financial losses as the trend toward remote interaction continues.

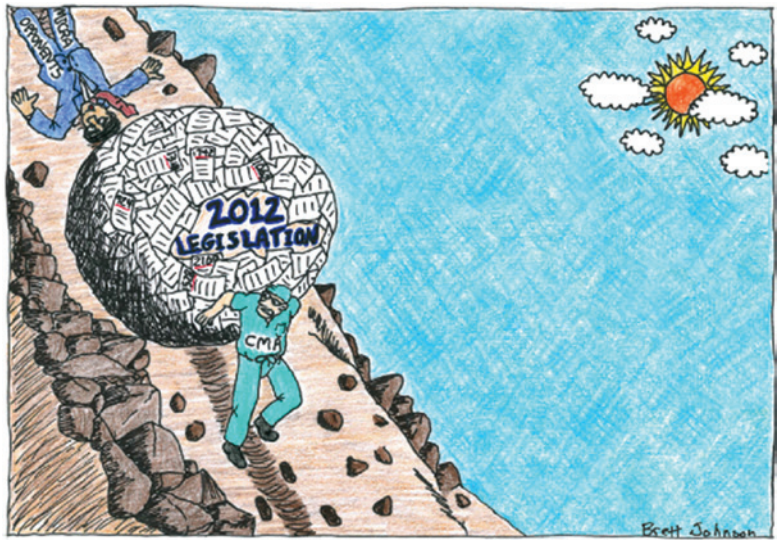
While support for the concept of requiring insurers to pay for telephone and email consults was nearly unanimous, the specific language of the resolution drew input from across the House, leading to nearly an hour of open discussion of the issue.

Ultimately, recognizing the importance of the matter and the limited time available for debate, delegates opted to refer the resolution to the CMA Board of Trustees for decision, an action which supporters claimed would allow the language to be crafted more thoughtfully.

The matter will likely be taken up during the board's January meeting and CMA staff will keep members updated on the resolution's progress.

One Must Imagine Sisyphus Happy

Jodi Hicks



In years past, the California Medical Association (CMA) has defended physicians in battles waged by hospitals, health plans and mid-level practitioners, but this year we initiated a few fights of our own. CMA did what physicians do best: we fought to protect patients.

CMA fought to keep patients out of the middle of billing disputes, to educate parents about immunizations, to require mandatory flu vaccinations for health care workers, to remove sugared beverages from schools, to create a physician health program, to expand residency programs, and to save the Healthy Families Program.

Sponsoring legislation is the equivalent of pushing rocks up a hill . . . or rather, big righteous boulders. The CMA Government Relations team struggled to push those rocks up the legislative hill while fighting off the enemies trying to get in the way, and at the same time stopping the many other rocks being thrown down at us. Sounds dramatic, but by all accounts, it was a crazy, precarious, contentious, hazardous and dramatic pathway to the finish line. We finished with some big wins. We lost a few battles along the way, but we fought for physicians and their patients until the very end.

Ms. Hicks is vice president of government relations for the California Medical Association.

CMA came out swinging from the starting gate in January. We introduced AB 1742 (Pan), which would have enabled patients to assign their benefits directly to the provider furnishing medical services. Sounds simple enough, but the bill soon came under attack from health plans and culminated in what was described on one blog as the "juiciest" Assembly Health Committee hearings of the year. After much back and forth, the bill came up one vote short before reaching a legislative deadline.

That same week, CMA battled the unions, championing a bill that would mandate flu vaccines for health care providers in hospitals. Against all odds and much opposition, SB 1318 (Wolk) moved through the state Senate in a decisive win for public health. Though CMA was able to maneuver this contentious bill all the way through the Legislature, it was subsequently vetoed by Governor Brown.

CMA also joined a large coalition of health care providers in a valiant attempt to create a physician health program in California. The coalition worked tirelessly to address the opposition's concerns surrounding funding, oversight and standards, and the bill made it all the way through committee hearings and was on its way to the floor when it stalled. Despite the coalition's diligence, the overwhelming demands of the opposition damaged the bill beyond repair before the last legislative deadline. Despite an end to this bill, we are confident that the conversation can continue. Physician health is an issue that CMA will look to advance next year.

And then came Rob Schneider. CMA—along with the American Academy of Pediatricians, the Health Officers Association of California and the California Immunization Coalition—sponsored AB 2109 (Pan) in an attempt to decrease the number of parents exempting their children from being vaccinated before entering public schools. Hundreds of anti-vaccine activists flooded the committee hearings to oppose the measure and eventually were joined by Saturday Night Live alum Rob Schneider. Now armed with "celebrity" status, the opposition was able to secure public rallies, television time and social media to oppose our efforts. Despite attempts at negative media attention by the opposition, Governor Brown signed AB 2109 into

law hours before the deadline.

The year wouldn't be complete without CMA revisiting some oldies but goodies, physical therapy and MICRA being no exceptions. Unfinished business from 2011, SB 924 (Steinberg/Price) would have fixed the ambiguity in law as to whether or not medical corporations can legally employ physical therapists; but it would have also allowed patients to directly access physical therapy treatment for 30 business days, at which time a physician would have to sign off on a physical therapy treatment plan. CMA had an official "oppose unless amended" position on the bill, asking for amendments that would have required a medical diagnosis after 30 days of direct treatment. The Assembly Appropriations Committee passed the bill, adding in medical diagnosis as a requirement for direct access. The California Physical Therapy Association again amended the bill on the floor, changing the language so that instead of requiring a diagnosis, it would require an examination or a diagnosis . . . and as the game of semantics wore on, the bill was quickly sent to the Assembly Rules Committee, where it stayed until its demise.

Two bills that would have weakened the protections of MICRA—SB 1528 (Steinberg) and AB 1062 (Dickenson)—were amended during the last week of the legislative session, adding to the chaos of the final days. The provider community strongly opposed both bills. Thanks to letters and phone calls from physicians across the state, both bills were ultimately killed with astoundingly low vote counts.

The legislative session officially ended early Saturday morning, Sept. 1. CMA's Government Relations team was at the Capitol until the very end. In the waning hours, CMA successfully negotiated key amendments into a Worker's Compensation bill and proudly fought to reinstate the Healthy Families Program as part of a complex deal that died sometime after 1 a.m. Despite bipartisan support for our efforts, Healthy Families became collateral damage to partisan politics. CMA continues to work with stakeholders on the transition of kids to Medi-Cal. More to come on this issue . . .

In his famous essay "The Myth of Sisyphus," French philosopher Albert Camus tells us that toil is not futile, and that hard work can be noble. CMA toiled throughout the year for physicians, honoring the labor physicians do for their patients every day. The struggle to push those legislative rocks up the hill was performed with pride. As Camus observes, "The struggle itself toward the heights is enough to fill a man's heart. One must imagine Sisyphus happy."

Of course, Sisyphus was not pushing the rock while simultaneously fighting lobbyists or Rob Schneider—but I still imagine him happy. ◇

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For details on the major bills that CMA followed this year, visit www.cal.md/legwrap2012.

NEW MEMBERS

Alex Barchuk, MD, Physical Medicine & Rehabilitation*, 1125 Sir Francis Drake Blvd., Kentfield 94904, Georgetown Univ 1985

Marek Bozdech, MD, Medical Oncology*, Hematology*, 101 Rowland Way #320, Novato 94949, Wayne State Univ 1972

Charles Elboim, MD, Surgery*, *Breast Diseases,* 121 Sotoyome St. #203, Santa Rosa 95405, Univ Vermont 1972

Laura Norton, MD, Surgery*, *Breast Diseases,* 121 Sotoyome St. , Santa Rosa 95405, Indiana Univ 2002

Jonathan Rutchik, MD, Neurology*, Occupational Medicine*, 20 Sunnyside Ave. #A-231, Mill Valley 94941, Hahnemann Univ 1990

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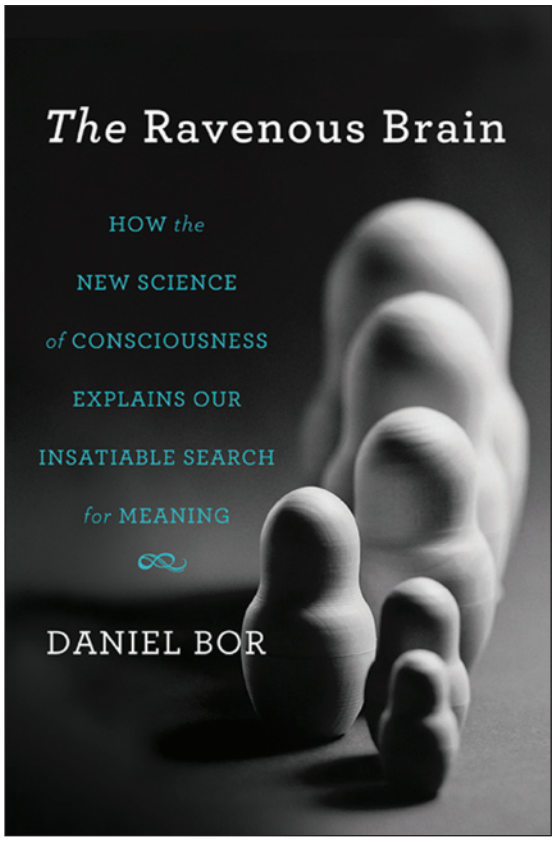
To Think, Perchance to Scheme

Irina deFischer, MD

The Ravenous Brain: How the New Science of Consciousness Explains Our Insatiable Search for Meaning, by Daniel Bor, Basic Books, 352 pages.



The Ravenous Brain is unlike any book I've ever read. The author, Daniel Bor, is a cognitive neuroscientist from Cambridge, England, currently working as a research fellow in consciousness science at the University of Sussex. He has a background in philosophy as well as biology, and he writes beautifully. He weaves into his treatise on consciousness examples from his own life, including his father's stroke, his wife's bipolar disorder, and his infant daughter's development. His book is densely written and not an easy read, but it is well worth the effort for anyone interested in the subject of consciousness.

Bor begins with a review of neuroanatomy and the evolution of the brain, as well as the brain's function at the cellular level. He goes on to interpret various brain studies that use functional MRIs and behavioral techniques, and he explains our use of finding patterns in order to organize and make sense of information. He describes the technique of "chunking" to reduce large amounts of material into more manageable bits that can be committed to memory. The complexity of the human brain—along with the self-awareness that sets us apart from other animals and from computers—has given us a great evolutionary advantage; but that complexity has also resulted in a susceptibility to mental illness.

Dr. de Fischer, a family physician at Kaiser Petaluma, is president of MMS.

An extended excerpt may give some idea of the density of Bor's prose and the nature of his argument. He writes: "We are so clever at spotting the patterns and tricks to meet our primitive desires that our lives can easily spiral out of control. Humanity's prodigious conscious tools of innovation can be devoted to discovering broad truths about the world. But they are just as easily co-opted to generate inventive tactics to have affairs, to overeat, to steal, or to pursue all manner of other short-term goals that are likely to backfire. . . . Our aggressive ability to form such packets of ideas and information perpetuates unhappy traps of thought, or even, occasionally, outright delusions, as we unwittingly reveal the delicate fragility of the human mind. . . . All of us, to varying degrees, are both the beneficiaries and the victims of our own consciousness."

In the final chapters of *The Ravenous Brain,* Bor explores the applications of consciousness science in understanding certain mental illnesses, including attention deficit disorder, schizophrenia, bipolar disorder, and autism. He then proposes novel approaches to treating these disorders based on his research findings. His book will certainly be of interest to mental health professionals, and perhaps to anyone affected by mental illness. ◇

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